2016-18 Executive Progress Report

Commonwealth of Virginia
Secretary of Health and Human Resources

Grants to Localities

At A Glance

Supporting individuals by promoting recovery, self-determination, and wellness in all aspects of life

Staffing 0 Salaried Employees, 0 Contracted Employees, 0 Authorized, and 0 Wage Employees.

Financials Budget FY 2017, $397.14 million, 83.30% from the General Fund.

Trends Legend ↑ Increase, ↓ Decrease, → Steady

Key Perf Areas
- ↑ SA service engagement
- ↑ Training center alternatives
- ↑ State hospital alternatives

Productivity
- ↑ Community inpatient savings

Legend ↑ Improving, ↓ Worsening, → Maintaining

For more information on administrative key, and productivity measures, go to www.vaperforms.virginia.gov

Background and History

Agency Background Statement

Community Services

The Department of Behavioral Health and Developmental Services (DBHDS) provides funding to the 39 community services boards and one behavioral health authority (referred to as CSBs), which serve as the single point of entry for public behavioral health and developmental services in Virginia. Although part of the DBHDS system of care, CSBs are established by the 133 local governments in Virginia and may serve single or multiple jurisdictions. CSBs are key operational partners in Virginia's public behavioral health and developmental services system and their relationship with DBHDS is based on the community services performance contract, provisions of Title 37.2 of the Code of Virginia, State Board policies and regulations, and other applicable state or federal statutes and regulations. Services provided by all CSBs are licensed by DBHDS.

Major Products and Services

Community mental health, developmental, and substance-use disorder services provided by or through CSBs include:

- Emergency services;
- Acute psychiatric and substance use disorder inpatient services, including medical detoxification;
- Outpatient services, including counseling and psychotherapy, medication services, intensive outpatient substance-use disorder services, intensive in-home services, assertive community treatment, medication-assisted treatment, and behavior management;
- Case management services;
- Day support services, including day treatment or partial hospitalization, ambulatory crisis stabilization, rehabilitation, and habilitation;
- Employment services, including individual supported, group supported, and sheltered employment;
- Residential services, including highly intensive - residential treatment centers, residential detoxification, and intermediate care facilities for individuals with intellectual disability; residential crisis stabilization; intensive - group homes, primary care, intermediate rehabilitation, and long-term habilitation; supervised - supervised apartments, domiciliary care, emergency shelter or respite, and sponsored placements; and supportive - supported living arrangements and housing subsidies;
- Prevention services; and
- Ancillary services, including motivational treatment, consumer monitoring, assessment and evaluation, and early intervention services.

Most, but not all CSBs provide Medicaid waiver services, Part C services, and peer services.

The Individual and Family Support Program (IFSP) provides up to $3,000 per year to eligible individuals with intellectual or developmental disabilities on waiver waiting lists and their families to purchase a wide array of supports, services, and other assistance that enable individuals to continue to live at home.

Customers

Customer Summary

Individuals who receive mental health, substance-use disorder, or developmental services and supports in community programs frequently exhibit serious or complex needs or medical conditions requiring specialized services. Many have significant behavioral challenges or co-occurring combinations of mental health or substance-use disorders or intellectual or other developmental disabilities.

DBHDS expects the number of individuals seeking community-based services will increase as Virginia's population grows (3.9 percent over the past five years) and coverage opportunities increase under the affordable health care act and other health reform measures.

Customer Table

Predefined Group	User Defined Group	Number Served Annually	Potential Number of Annual Customers	Projected Customer Trend
Consumer	Individuals receiving CSB developmental services	20,938	27,303	Increase
Consumer	Individuals receiving CSB mental health services	115,669	185,880	Increase
Consumer	Individuals receiving CSB substance-use disorder services	30,180	40,924	Increase
Consumer	Individuals receiving CSB emergency or ancillary services	155,394	160,522	Increase
Child	Infant and toddlers and their families served in Part C early intervention services	17,839	18,731	Increase

Finance and Performance Management

Finance

Financial Summary

Funds depicted in the table below include general fund dollars and federal funds derived from the Substance Abuse Prevention and Treatment (SAPT) and the Community Mental Health Services (CMHS) block grants funded by the Substance Abuse and Mental Health Administration (SAMHSA); Part C Early Intervention grant funds for infants and toddlers with developmental delays; and other grants for SA and MH services.

CSBs also receive funds from other sources such as local funds, Medicaid, other fees, and other revenues. These funds are not appropriated by the Commonwealth and are not included in the Appropriation Act and, therefore, are not included in the following table.

Fund Sources

Fund Code	Fund Name	FY 2017	FY 2018
0100	General Fund	$330,827,537	$349,491,728
0908	Mental Health/Retard Substance Abuse Srvs Trust Fd	$4,000,000	$8,550,000
1000	Federal Trust	$62,315,447	$67,159,447

Revenue Summary

Revenue collections are from various federal grant funds including the Substance Abuse Prevention and Treatment (SAPT) and the Community Mental Health Services (CMHS) block grants funded by the Substance Abuse and Mental Health Administration (SAMHSA); Part C Early Intervention grant funds for infants and toddlers with developmental delays; and other grants for SA and MH services.

Performance

Performance Highlights

Important measures of performance of community behavioral health and developmental services involve the intensity of case management services and the retention of individuals in substance use disorder services.

- Active engagement of individuals in case management services allow case managers to observe and assess individuals' needs and preferences; ascertain if supports and services are being implemented appropriately; and determine if supports and services remain appropriate or should be changed.

- Intensity of engagement by adults with serious mental illness in mental health case management services is measured by the percentage of individuals who received at least four hours of services within 90 days of admission.
- Provision of in-home developmental case management services to specific groups receiving face-to-face visits under the settlement agreement with the U.S. Department of Justice reflects the degree to which individuals are actively engaged.
- One of the principles of effective treatment of substance-use disorders is that an individual's involvement in on-going treatment significantly reduces or stops drug use and that the best outcomes occur with longer durations of treatment. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment. Retention in services is measured by the percentage of individuals admitted to substance use disorder services during the past year who remain engaged for at least six months.
- DBHDS is using two measures of the ability of CSBs to implement new requirements related to civil temporary detention orders (TDOs). These measures specifically track the number of temporary detention orders (TDOs) for which state facilities served as the last resort because a community facility was not found at the end of emergency custody order (ECO) period, and the rate of state hospital civil TDO admissions. The 2014 General Assembly amended the Code of Virginia to require state hospitals to accept civil TDO admissions if other alternatives have not been identified within the eight hour emergency custody order period. Based on data to date, this legislation has already resulted in a significant increase in TDO admissions to state hospitals.

Selected Measures

Measure ID	Measure	Alternative Name	Estimated Trend
M790SA12001	Percentage of adults admitted for substance abuse outpatient services who receive at least three hours of outpatient services within 30 days of admission.	SA service engagement	Improving
M790SA12004	Percentage of costs avoided by using community acute inpatient psychiatric services.	Community inpatient savings	Improving
M790SA12005	Percentage of individuals receiving intensive developmental services who are served in the community.	Training center alternatives	Improving
M790SA12003	Percentage of individuals receiving intensive mental health services who are served in the community.	State hospital alternatives	Improving

Key Risk Factors

Several factors will have a significant effect on community services providers over the next four years.

- ***Mental health services system reforms:*** The services system is multifaceted, extremely complex, underfunded, and under resourced and may be difficult to navigate for individuals in crisis and families who are seeking assistance. It also is challenging for providers because it requires effective communication and collaboration among many partners, including CSBs and private hospitals, law enforcement, and the judicial system. Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century created by the 2014 session of the General Assembly is currently studying the Commonwealth's behavioral health services system. Implementation of potentially significant system reforms emanating from these efforts may change how the current system operates.
- ***Inadequate behavioral health service capacity:*** Although mental health is a crucial component of individual and community wellness, access to needed community behavioral health services varies significantly across the state. Service availability is limited by notable gaps in important basic services such as crisis, emergency, acute inpatient, outpatient, case management, and psychiatry services and recovery-focused housing and employment supports. In particular, the prevention and early intervention system is underdeveloped and very few targeted investments in recent years went to early intervention. Even with funds provided by the General Assembly during the last several sessions to expand crisis, local inpatient, assertive treatment, and other priority services, continued investments in innovative, evidence-based mental health and substance-use disorder services programs, particularly trauma-informed crisis management and interventions focused on prevention and early intervention, are needed to address capacity issues.
- ***Inadequate developmental service capacity:*** To meet the requirements of the Commonwealth's settlement agreement with the U.S. Department of Justice (DOJ), major expansion of new or enhanced waiver slots, work and housing supports, and crisis services is required to support individuals who are living in the community and those who are transitioning from training centers to the community. As of April 6, 2017, there were 11,396 individuals on the Medicaid developmental disability waiver waiting list.
- ***Implementation of Health Care Reforms:*** Increasingly, CSBs and private providers are being affected by new service delivery requirements associated with Medicaid care coordination and managed behavioral care initiatives. The low income threshold for Medicaid presents challenges for providing services for uninsured and underinsured individuals. Changes resulting from potential health care reforms include the loss of CSB general fund dollars that now support services to individuals who would become eligible for Medicaid services if Medicaid coverage were expanded; provider workforce capacity pressures resulting from increasing demands for services by newly insured enrollees and Medicaid enrollees; and potential changes to the arrays of federal mental health and substance abuse block grant services.
- ***Continuing Opioid Epidemic:*** The Office of the Chief Medical Examiner (VDH) has predicted that deaths from drug overdose will exceed 1,400 in 2016, an increase of 38 percent over 2015. This is the fourth consecutive year that deaths from this cause have increased. OCME has not yet published data for the specific drugs that caused death, however, deaths attributed to opioids increased 33.42% between 2014(353) and 2015 (471), and the introduction of synthetic opioids has likely contributed to more deaths in the current year. General fund allocations that support basic treatment services for SUDs have been level for years, even as the need for services and the complexity of the needs of those receiving services increases. The FDA has approved three medications for the treatment of opioid use disorder

(specifically, Medication Assisted Treatment (MAT)), yet fewer than half of the CSBs have the capacity to offer this lifesaving intervention, let alone to provide complex clinical supports. CSB capacity to treat individuals with SUDs has remained static at about 30,000 unduplicated individuals per year, and an increasing proportion (currently about 40%) are presenting with opioid use disorder. Although DBHDS received a $9.76 million one-year federal grant in 2017 (with an additional year possible), these funds are only for one year and cannot be used to address longstanding infrastructure needs such as bricks and mortar or workforce development that are necessary to expand capacity. $5 million of these funds is dedicated to expand access to MAT with necessary clinical care, for an expanded static capacity of 500 MAT slots per year. However, there are clearly many more individuals who will need services who won't be able to access MAT.

Agency Statistics

Statistics Summary

The following statistics provide a snapshot of CSB operations:

Statistics Table

Description	Value
Number of CSB employees (FTEs) – FY 2016	13,237
CSB total resources – FY 2016 all revenues	1,160,435,761
CSB fees as percent of total revenues – FY 2016	42
Local government percent of total CSB resources – FY 2016	23
Number of individuals and families receiving IFSP funding – FY 2016	2,944

Management Discussion

General Information About Ongoing Status of Agency

DBHDS is working with CSBs and other community service providers to:

- Implement recovery and resiliency principles and recovery support services across Virginia;
- Expand access to and availability of evidence-based and best practice behavioral health care, including same day access, integrated behavioral and physical health approaches, trauma-informed services for all individuals and families, comprehensive and integrated children's programs, community-based services appropriate to support individuals being discharged from state hospitals such as Programs of Assertive Community Treatment and Permanent Supportive Housing, additional drop-off centers to provide an alternative to incarceration for individuals with serious mental illness, additional mental health inpatient treatment purchased in community hospitals, and expansion of tele-psychiatry services;
- Provide flexible and individualized developmental services and supports that keep families intact and reduce the need for costly out-of-home placements, including enhanced case management/care coordination, crisis services for adults and children and adolescents with developmental disabilities, and expanded opportunities for integrated housing and competitive employment, and assist in increasing and improving capacity in the community;
- Improve service provider transparency and accountability through the community services performance contract with CSBs and finance and program reviews of CSBs, DBHDS licensing of services and human rights protections, risk management and quality improvement processes, and monitoring provider performance and outcomes.

Information Technology

The 40 community services boards (CSBs) maintain their own information technology (IT) systems, or these systems are maintained by their local governments. However, they do rely on DBHDS central office for core reporting applications such as the Community Automated Reporting System (CARS) to provide semi-annual reporting on performance contract financial metrics, the Community Consumer Submission (CCS3) application to report demographic, clinical, and services data monthly on the more than 216,000 individuals who receive services from CSBs, and the new Waiver Management System (WaMS) for Medicaid Developmental Disability waiver enrollments, service authorizations, and determinations regarding retaining slots.

Eliminating as much double entry as possible between CSB systems and DBHDS systems improves efficiency and reduces errors in information that appear in multiple records. However, because WaMS is also an authorization system designed to be accessed by providers, case managers, and authorization staff, case managers (and CSBs with direct services) will have to work in two systems (WaMS and local electronic health record systems). The effort to create a method for data exchanges between WaMS and CSB electronic health record systems (EHRs) is compounded by the diverse nature of the different business functions across CSBs, and the cost of the data exchange may not be offset with productivity gains by the users.

CSBs have purchased electronic health record information systems from various vendors; Credible (21 21), Cerner (8), CoCentrix (8), and one each for AVATAR, CMHC, and PsyhConsult. All CSBs have implemented certified EHRs. CSBs are also in varying stages of pursuing meaningful use certification and funding.

While most CSBs have in-house IT staff, some CSBs do not. This poses challenges to those CSBs, particularly regarding data quality and using data for management purposes. The added data reporting requirements associated with the DOJ Settlement Agreement are imposing significant workload burdens on CSB IT systems as well as service staff.

Statewide service and financial data is not readily available to CSBs, in part due to the absence of a statewide data sharing environment accessible to CSBs. The DBHDS IS&T approach to solving this problem is two-fold. First, the DBHDS OneSource Data Warehouse has the capability of acting as a reporting and analytics platform for the CSBs. Second, web service-based data exchanges have been developed to automate the sharing of data between CSB and DBHDS systems, most notably in the Infants and Toddlers Online Tracking System (ITOTS). DBHDS IS&T intends to extend this approach by coordinating CSB use of OneSource with the DBHDS Quality Management division, and by adding additional data exchanges to connect CSB system to other DBHDS central office applications.

Workforce Development

Operating CSBs and the BHA maintain their own human resources management and development systems, while administrative policy boards are part of their local government systems. Many CSBs, especially those not part of local governments, face continuing challenges in attracting and retaining well-qualified staff due to lack of resources for adequate compensation. Additionally, some rural CSBs face special challenges in attracting staff to their areas. CSB recruitment and retention issues are further exacerbated by the lack of state funding for salary increases in recent years.

All CSBs will face challenges in adapting to and complying with their employer responsibilities under the Affordable Care Act related to health insurance. While all large and many medium size CSBs have in-house HRM staff, some medium and most small CSBs do not. This poses challenges to those CSBs in effectively managing their human resources.

Physical Plant

Operating CSBs and the BHA maintain their own buildings. Ownership and leasing arrangements vary for the 13 group homes funded through DBHDS and constructed in Region 5 (Eastern Virginia) for individuals with intellectual disabilities who are leaving Southeastern Virginia Training Center. Similarly, DBHDS has approved funding of 13 homes for individuals who are leaving Central Virginia Training Center. Eight of these homes have been constructed; one is in the final design with construction to begin in the summer. Additionally, Rappahannock Area CSB has built one home in Fredericksburg; Danville Pittsylvania Community Services was funded for its last home in 2015; and Horizon Behavioral Health was awarded funding for a four-bed home to come online in 2018. DBHDS has distributed funds for the development of community homes for individuals residing at Central Virginia Training Center.

NOTE: This is one of five DBHDS Executive Progress Reports. See Department of Behavioral Health and Developmental Services (720); Mental Health Treatment Centers (792); Intellectual Disabilities Training Centers (793); and Virginia Center for Behavioral Rehabilitation (794).